ATTACHMENT 4.19-A
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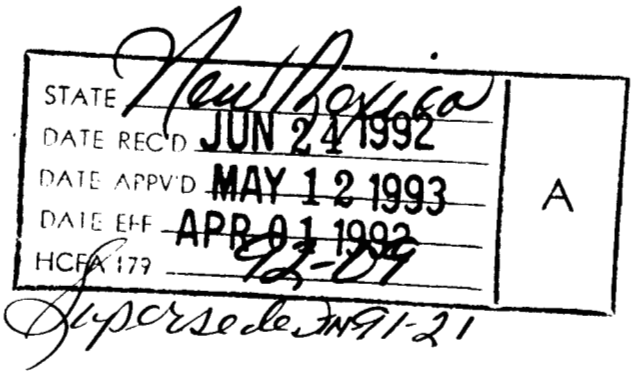

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT HOSPITAL SERVICES

The New Mexico Title XIX Program reimburses appropriately licensed and certified acute care hospitals for inpatient services as outlined in this plan. Procedures and policies governing state licensure, certification of providers, utilization review, and any other aspect of State regulation of the Title XIX Program not relating to the method of computing payment rates for inpatient services are not affected by this plan.

I. GENERAL REIMBURSEMENT POLICY

The State of New Mexico Human Services Department (hereafter called the Department) will reimburse inpatient hospital services rendered on or after October 1, 1989 in the following manner:

A. Covered inpatient services provided to eligible Medicaid recipients admitted to in-state acute care hospitals and acute care inpatient units on or after October 1, 1989 will be reimbursed at a prospectively set rate, determined by the methodology set forth in Section III of this plan, unless the hospital or unit is classified into one of the prospective payment system (PPS) exempt categories outlined in subsections C through E below.

B. Covered inpatient services provided to eligible recipients of the New Mexico Medicaid program, when treated in border area hospitals (i.e., those hospitals located within 100 miles of the New Mexico border, Mexico excluded) will be reimbursed at a prospectively set rate as described in Section III.C.16 of this plan.

C. Inpatient services provided in Rehabilitation and Children's hospitals and Medicare PPS-exempt distinct part units within hospitals will be reimbursed using the provisions and principles of reimbursement set forth in Public Law 97-248. This legislation, which was effective October 1, 1982, is commonly referred to as TEFRA (Tax Equity and Fiscal Responsibility Act) and is described in Section II of this plan.

Pediatric, psychiatric, substance abuse, and rehabilitation cases treated in non-exempt general acute care hospitals or non-PPS-exempt units will be included in the PPS.

D. Indian Health Services hospitals will be reimbursed using a per diem rate established by the Federal Government.

E. Covered inpatient services provided by out-of-state hospitals (i.e., those hospitals located more than 100 miles from the New Mexico border, Mexico excluded) will be reimbursed on a percent of charge basis. All non-border out of state hospital claims will be reimbursed at a rate consisting of 70 percent of the provider's allowable billed charges. Covered inpatient services provided in specialty hospitals and Medicare PPS-exempt distinct part units within hospitals will be reimbursed at 70 percent of allowable charges or a negotiated rate, not to exceed the rate paid by federal programs such as CHAMPUS or Medicare. Negotiation of rates will only be allowed when the Department determines that the specialty hospital or specialty unit provides a unique service required by Medicaid recipients.

F. New providers entering the Medicaid program will be reimbursed at the peer group median rate for the applicable peer group, until such time as rebasing occurs, unless the hospital meets the criteria for prospective payment exemption as described in subsections C through E above.

G. All hospitals which meet the criteria in Section IV.A of this plan will be eligible for a disproportionate share adjustment.

H. Effective for discharges on or after April 1, 1992, and in accordance with Section 4604 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Department provides for an outlier adjustment in payment amounts for medically necessary inpatient services involving exceptionally high costs or long lengths of stay for children who have not attained the age of six years in disproportionate share hospitals, and for infants under age one in all hospitals. The outlier adjustment for these cases is described in Section III. F. of this plan.

STATE New Mexico
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II. PAYMENT METHODOLOGY FOR PPS-EXEMPT HOSPITALS AND EXEMPT UNITS WITHIN HOSPITALS

A. Application of TEFRA Principles of Reimbursement

1. The principles and methods identified in Public Law 97-248 provision (TEFRA), effective October 1, 1982, regarding allowable payment for inpatient hospital services, and any subsequent changes to such provision shall be used to determine:
   - The amount payable by the Department through its fiscal agent for services covered under the Medical Assistance Program and provided to Title XIX recipients; and
   - The manner of payment and the manner of settlement of overpayments and underpayments for inpatient services provided by hospitals for Title XIX reimbursement purposes, effective for all accounting periods which begin on or after October 1, 1983.

2. The inflation factor used in the calculations will be identical to that used by Medicare to update payments to hospitals which are reimbursed using the TEFRA methodology, except for services rendered during the period October 9, 1991, through September 30, 1992, for which the inflation factor will be .5% for urban hospitals and 1.5% for rural hospitals.

3. In accordance with Section 1902 (s)(3) of the Social Security Act effective July 1, 1991, the TEFRA rate of increase limit for inpatient hospital services will not apply to the delivery of such services to any individual who has not attained their first birthday (or in the case of such individual who is an inpatient on his first birthday until such individual is discharged).

B. Appeals

1. Hospitals may appeal the target rate and application of same, if circumstances beyond the hospitals' control have caused the reimbursement rates to fall at least five percent below actual allowable costs.

2. Such appeals must be filed in writing within 180 days of the notice of final settlement and must contain sufficient supporting documentation to demonstrate that the circumstances causing the situation were not

within the control of the hospital and that the continued imposition of the target rate would cause a significant financial hardship.

3. The Department shall review the supporting documentation and, if appropriate, grant an exemption from or modification of the target rate. The Department's determination on the merits of the appeal will be made within 180 days of receipt of the appeal request, although the State may make a determination to extend such period to a specified date as necessary.

III. PROSPECTIVE PAYMENT METHODOLOGY FOR HOSPITALS

Payment for all covered inpatient services rendered to Title XIX recipients admitted to acute care hospitals (other than those identified in Section I, subsections C through E) on or after October 1, 1989 shall be made based on a prospective payment approach which compensates hospitals an amount per discharge for discharges classified according to the Diagnosis Related Group (DRG) methodology. The prospective rates for each hospital's Medicaid discharges will be determined by the Department in the manner described in the following subsections.

A. Services Included In or Excluded From the Prospective Payment Rate

1. Prospective payment rates shall constitute payment in full for each Medicaid discharge. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as described below. Hospitals may submit a claim for payment only upon the final discharge of a patient or upon completion of the transfer of the patient to another acute care hospital.

2. The prospective payment rate shall include all services provided to hospital inpatients, including:

a. All items and non-physician services furnished directly or indirectly to hospital inpatients, including but not limited to 1) laboratory services; 2) pacemakers and other prosthetic devices including lenses and artificial limbs, knees and hips; 3) radiology services including computed tomography (CT) or magnetic resonance imaging (MRI) scans furnished to patients by a physician's office, other hospital or radiology

clinic; 4) transportation, (including transportation by ambulance), to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services.

3. Services which may be billed separately include:

   a. Ambulance service when the patient is transferred from one hospital to another and is admitted as an inpatient to the second hospital.

   b. Physician services furnished to individual patients.

B. Computation of DRG Relative Weights

1. Relative weights used for determining rates for cases paid by DRG under the State Plan shall be derived, to the greatest extent possible, from New Mexico Medicaid hospital claim data. All such claims are included in the relative weight computation, except as described below.

2. Hospital claim data for discharges occurring from January 1, 1985 through approximately the end of calendar year 1988 are included in the computation and prepared as follows:

   a. Claims are edited to merge interim bills from the same discharge.

   b. All Medicaid inpatient discharges will be classified using the Diagnostic Related Group (DRG) methodology, a patient classification system that reflects clinically cohesive groupings of inpatient cases which consume similar amounts of hospital resources. Claims are assigned to appropriate DRGs using Version 6.0 of the Health Systems International DRG grouper software.

   c. Claims included in the computation of DRG relative weights were restricted to those claims for cases to be included in the proposed PPS. Claims for services provided in PPS-exempt hospitals or units (or for services otherwise exempt from the PPS) were not used to compute DRG relative weights.

3. Charges for varying years are adjusted to represent a common year through application of inflation indices as described in Section III.C.8 of this plan.

4. Initial relative weights are computed by calculation of the average Medicaid charge for each DRG category divided by the average charge for all DRGs.

5. Where the New Mexico Medicaid-specific claims and charge data are insufficient to establish a stable relative weight , a relative weight is imported from other sources such as the CHAMPUS or Medicare prospective payment systems. Weights obtained from external sources are normalized so that the overall case mix is 1.0.

6. The relative weights computed as described above shall remain in effect until the next year. At that time, the relative weights will be recalibrated using whatever DRG Grouper version is currently in use by Medicare.

C. Computation of Hospital Prospective Payment Rates

1. Rebasing of Rates

Beginning October 1, 1997, the Department will discontinue the rebasing of rates every three years. Hospital rates in effect October 1, 1996 will be updated every October 1 using the prospective payment system hospital market basket index forecasts published in the HCFA Dallas Regional Medical Services letter issued for the quarter ending in June each year. For example, the Department will use the Dallas Regional Medical Services letter issued for June 1998 to determine the inflation factor that will be used to update rates October 1, 1998.

2. Base Year Discharge and Cost Data

a. The State's fiscal agent will provide the Department with Title XIX discharges from audited or desk reviewed cost reports for reporting periods ending in calendar year 1993 and inflated forward to the midpoint of federal fiscal year 1997 using the update factors specified in III.C.8.

- Effective for services on or after October 1, 1997, the rates that were in effect as of October 1, 1996 will be updated.

- The rates will be updated annually for inflation, effective October 1 each year, using the methodology in paragraph C.1.

- Cost reporting periods ending in 1993 are used as the base year for the rates in effect as of October 1, 1996.

  The October 1, 1996 base year cost per discharge was determined from Title XIX discharges from audited or desk reviewed cost reports for reporting periods ending in calendar year 1993 and inflated forward to the midpoint of the federal fiscal year 1997 using the update factors specified in III.C.8 — as described in paragraphs C.2.b. through C.13. Below.

  The operating cost per discharge and the excludable cost per discharge as of October 1, 1996 will be combined into one base year cost per discharge. The combined base year cost per discharge will be updated for inflation using the update factor in paragraph C.1.

- The excludable cost per discharge will be handled in the same manner as described in III.E.

- The methodology described in paragraphs C.2.b. through C.13. below represent the methodology in effect prior to October 1, 1997, and is retained intact in the state plan solely to document how the rates in effect as of October 1, 1996 were determined.

b. The State's audit agent will provide Title XIX costs incurred, reported, audited, and/or desk audited for the same period.

c. To calculate the total reimbursable inpatient operating costs from the cost and discharge data described above, the Department will:

- Exclude estimated outlier discharges and costs as described in Section III.C.4 of this plan.
- Exclude pass-through costs, as identified in Public Law 97-248 (TEFRA) provisions and further defined in subsection C.3 below.

3. Definition of Excludable Costs Per Discharge; Reduction of Excludable Capital Costs

a. The approach used by the Department to define excludable costs parallels Medicare's approach. Excludable costs are defined according to the PPS or TEFRA methodology and include such costs as those associated with capital, organ acquisition, and certified nurse anesthetists.

b. The pass-through capital costs identified using TEFRA [provisions will be reduced in a manner similar to that employed by the Medicare PPS. For example, excludable capital costs for fiscal year 1989 will be reduced by 15 percent as required by Section 4006 of Public Law 100-203 (Omnibus Budget Reconciliation Act of 1987). However, any such reduction to pass-through capital costs will only apply to those costs incurred after October 1, 1989.

4. Outlier Adjustment Factors

Hospital-specific outlier adjustment factors will be used to deduct outlier costs and cases from the total Medicaid inpatient operating costs and cases used in rate setting. These factors will be determined by using actual claim and cost data for outlier cases for the base year period. Only claims for cases to be paid by DRG will be included in the analysis used to determine this estimate. The definition of an outlier case can be found in Section III.F.1. of this plan.

5. Calculation of Base Year Operating Cost Per Discharge

The total reimbursable inpatient operating cost (excluding pass-through costs and estimated outlier costs) is divided by the hospital's number of non-outlier Medicaid discharges to produce the base year operating cost per discharge. The base rate methodology is described below.

$$BYOR = \frac{OC}{D}$$

BYOR = Base year operating cost per discharge
OC = Total Title XIX inpatient operating cost for the base year, less excludable costs and estimated outlier costs
D = Medicaid discharges for the hospital's base year as provided by the Department's fiscal agent, less estimated outlier cases.

6. Possible Use of Interim Base Year Operating Cost Per Discharge Rate.

a. If the fiscal agent and audit agent have not provided the Department with a hospital's base year discharges and costs as of June 1 prior to Year 1, the Department will develop an interim operating cost per discharge base rate. This rate will be developed according to the normal base rate methodology, but using costs and discharges for the fiscal year prior to the base year.

b. When an interim rate is developed, the operating costs per discharge are first multiplied by an inflation index (as described in Section III.C.8 of this plan) to bring the costs to the midpoint of the base year. When the provider's actual base year costs and discharges become available, the Department will calculate a final base year operating cost per discharge using the normal base rate methodology. The rate that is computed from the final base year operating costs per discharge will apply to all discharges in Year 1, retroactive to the effective date of the interim rate.

7. Prohibition Against Substitution or Rearrangement of Base Year Cost Reports

a. A hospital's base year cost reports cannot be

substituted or rearranged once the Department has determined that the actual cost submission is suitable. A submission shall be deemed suitable 180 days from the date of the Notice of Proposed Rate (NPR) issued by the State's intermediary in the absence of an appeal by the hospital to the intermediary and the State.

b. In the event of such an appeal, the State must make a written determination on the merits of the appeal within 180 days of receipt, although the State may make a determination to extend such period to a specified date as necessary. Once such an appeal has been determined, the resulting base cost will be effective retroactively to Year 1 and will not be changed until subsequent rebasing of all hospitals has been completed.

8. Application of Inflation Factors

a. The inflation factors used to update operating costs per discharge will be identical to those established by Congress and adopted for use by the Health Care Financing Administration (HCFA) to update Medicare inpatient prospective payment rates. The Medicare prospective payment update factor (MPPUF) is determined by HCFA, usually on an annual basis, and may differ depending upon the hospital type (urban, large urban, or rural) as defined by HCFA.

b. Each hospital's base year operating cost per discharge will be indexed up to the common point of December 31 falling prior to Year 1, using the applicable Medicare prospective payment update factors (MPPUF) for that hospital for that period. That is, the inflation factors used will be identical to those established by Congress and adopted for use by HCFA to update Medicare inpatient prospective payment rates, including any established differential for urban and rural hospitals. Then this value will be indexed using the applicable MPPUF corresponding to the period beginning October 1 (prior to Year 1) and ending with the midpoint of operating Year 1. For Years 2 and 3, the inflation factors will be the applicable MPPUF as specified by HCFA.

c. For the period October 9, 1991, through September 30, 1992, an exception to a. and b. above will be